WellDyneRx Prescription Drug Claim Form

INSTRUCTIONS:

1. Fill out all of the information on the claim form as completely as possible.
2. **Please complete a separate claim form for each family member.**
3. Provide an original receipt with prescription details from your pharmacy. Cash register tape and photo copies will not be accepted.
4. If necessary, contact the pharmacist to provide the detailed drug information requested on the form for the prescription(s) dispensed.
5. Please provide the complete name, address and telephone number of the pharmacy. Should you or the pharmacist have questions regarding the completion of this form, please call our toll-free number **888-479-2000.** You can reach us between the hours of 7:00 a.m. and 7:00 p.m. (MST), Monday through Friday and 8:00 a.m. to 12:00 p.m. (MST) Saturday.
6. Mail the completed form and original receipts directly to:

   WELLDYNERX
   PO BOX 4517
   ENGLEWOOD, CO 80155
7. You will receive a response within 30 days.

Use this form to be reimbursed for each prescription that you purchased without your prescription card. You will be reimbursed network pharmacy rates, less co-pays.

EMPLOYEE INFORMATION	PATIENT INFORMATION
Employer's Name Group Number	Patient's Last Name First Name Middle Initial
Last Name First Name Middle Initial	Birthdate (mo/day/yr) _____/_____/_____
Cardholder ID#	Male ❑ Female ❑
Address	Patient's Relationship to Employee:
City, State, Zip Code	Self ❑ Spouse ❑ Child ❑ Other ❑
Daytime Phone Number (_____)_____	

PRESCRIPTION #1 INFORMATION	PRESCRIPTION #2 INFORMATION
Rx Number Date Filled	Rx Number Date Filled
Quantity Days Supply Amount Paid	Quantity Days Supply Amount Paid
Prescribing Doctor DEA Number or Name	Prescribing Doctor DEA Number or Name
Medication Name and Strength (mg.,ml.,etc.)	Medication Name and Strength (mg.,ml.,etc.)
NDC Number: _____	NDC Number: _____
Is the Drug: (Check All That Apply)	Is the Drug: (Check All That Apply)
❑ New Prescription ❑ Refill	❑ New Prescription ❑ Refill
❑ Compound Rx ❑ Allergy Injectable	❑ Compound Rx ❑ Allergy Injectable

PRESCRIPTION #3 INFORMATION			PRESCRIPTION #4 INFORMATION		
Rx Number		Date Filled	Rx Number		Date Filled
Quantity	Days Supply	Amount Paid	Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name			Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg.,ml.,etc.)			Medication Name and Strength (mg.,ml.,etc.)		
NDC Number: _____ Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable			NDC Number: _____ Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

PRESCRIPTION #5 INFORMATION			PRESCRIPTION #6 INFORMATION		
Rx Number		Date Filled	Rx Number		Date Filled
Quantity	Days Supply	Amount Paid	Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name			Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg.,ml.,etc.)			Medication Name and Strength (mg.,ml.,etc.)		
NDC Number: _____ Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable			NDC Number: _____ Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

Pharmacy Name Address City State Zip Code

Pharmacy Telephone Number NPI Number

I certify that the information on this claim form is correct and authorize release of all information to WellDyneRx and the Plan Sponsor. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan. I verify that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

This form must be signed _____
Employee/Member's Signature Date